INVOLUNTARY LOSS OF COVERAGE STATEMENT

I certify that my spouse or dependent, through no election of their own, has lost health and/or dental care coverage effective _____. Involuntary loss of coverage means a layoff, a plant or business closing, or being fired/discharged. A spouse's or dependent's choice to voluntarily resign or retire is not an involuntary loss of coverage for health and/or dental care coverage purposes.

I understand that to add coverage for my spouse and any dependents listed below, I must already have a single or family contract in force with the State of Iowa. An enrollment form must be completed within 30 days of the loss of coverage and submitted with the Involuntary Loss of Coverage form which has been signed and dated by the previous employer. Coverage will become effective the first of the month following the involuntary loss. [Any false statements or misrepresentations will void the contract(s) applied for and benefits will not be paid to any person covered by the contract(s)].

Department: _____

Employee's Name: _____ Soc. Sec. No.: _____
(type or print)

Employee's Signature _____ Date _____

Spouse's Name: _____ Spouse's SS# _____

Names of Dependents Previously Covered Under Spouse's Plan: **Dependent's SS #**

_____ _____

_____ _____

Spouse's Former Employer: _____

Health Coverage: Family ☐ Single ☐ _____
Name of Health Carrier

Dental Coverage: Family ☐ Single ☐ _____
Name of Dental Carrier

TO BE COMPLETED BY FORMER EMPLOYER

I certify that the spouse or dependent listed above has lost coverage as defined above on _____
(last day of coverage)

Signature: _____ Title: _____

Company Name: _____ Date: _____

Address: _____ Phone # (___) _____

Please attach this form to the employee's application(s) for additional coverage.
Comments may be noted on the reverse side of this form.